



GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH – HEALTH PROFESSIONAL LICENSING ADMINISTRATION

NEW REGISTRATION APPLICATION

Registration Programs

Please read instructions before completing this form. If you have any questions, call HPLA's toll-free Customer Service line at **1-877-540-5828** Monday through Friday, 8AM to 5PM EST. **A charge of \$65.00 will be imposed for dishonored checks (public Law 89-208).**

SECTION 1. REQUESTED REGISTRATION TYPE/FEEs (includes non-refundable application fee – see instructions)

☐ DT – Dance Therapist by Endorsement \$ 176.00

☐ Duplicate Registrations (limit 5) ____ X \$26.00 = \$ ____ .00

Total Enclosed \$ ____ .00

Make check or money order payable to Promissor, Inc.

MAIL TO:

Department of Health
Health Professional Licensing Administration
Dance Therapy Registration
717 - 14th St NW
Suite 600
Washington, DC 20005

HPLA ONLY		
Check \$	Check #	Staff
\$ ____ .00		

SECTION 2. APPLICANT NAME/DEMOGRAPHIC INFORMATION

Enter your name exactly as it should appear on the registration. If your name has changed at any point since you first attended college or university, please complete Section 4 on page 2. You must also provide a copy of a legal name change document for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

FIRST NAME MI LAST NAME SUFFIX
(Jr, Sr, etc.)

SOCIAL SECURITY NUMBER
If applicant does not provide a social security number, a sworn affidavit is required.

DATE OF BIRTH

PLACE OF BIRTH
Provide City and State for US birthplace or Country for foreign place of birth.

☐ Male ☐ Female
GENDER
Please check the correct box.

Section 3. SUPPORTING DOCUMENTS REQUIRED

Please indicate the supporting documents you have included with this package or requested to be sent to the Dance Therapy Registration. Keep a photocopy of all supporting documents for your records.

HPLA ONLY

A.	Two recent and identical passport-type photos of the applicant's face (approx. 2"X2") with applicant's name printed on the back. <u>The photos must be original photos and cannot be computer-generated copies or paper copies.</u>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
B.	Copy of American Dance Therapeutic Association (ADTA) Registration.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
C.	Completed signed application.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
D.	Copies of legal documents supporting all name changes.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>

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Section 4. PREVIOUS NAMES

If your name has changed at any point since you first attended college or university, you must provide a copy of a legal name change document for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate

<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> <div style="display: flex; justify-content: space-between;">FIRST NAMEMILAST NAMESUFFIX (Jr, Sr, etc.)</div>
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Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate

<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> <div style="display: flex; justify-content: space-between;">FIRST NAMEMILAST NAMESUFFIX (Jr, Sr, etc.)</div>
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Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate

<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> <div style="display: flex; justify-content: space-between;">FIRST NAMEMILAST NAMESUFFIX (Jr, Sr, etc.)</div>
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Section 5A. HOME ADDRESS

Even if you have a PO Box, a street address should also be provided, if applicable.

☐ APARTMENT ☐ SUITE ☐ FLOOR ☐ PO BOX NUMBER

HOME STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise, use this line to indicate STREET NUMBER and STREET NAME)

HOME STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY

<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>	—	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>
STATE		ZIP CODE + 4

<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>	—	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>	—	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>
HOME PHONE NUMBER		HOME FAX NUMBER		

Section 5B. BUSINESS ADDRESS

Please note: This information will be made available to the public.

COMPANY NAME

☐ APARTMENT ☐ SUITE ☐ FLOOR ☐ PO BOX NUMBER

BUSINESS STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise use this line to indicate STREET NUMBER and STREET NAME)

BUSINESS STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY

<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>	—	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>
STATE		ZIP CODE + 4

<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>	—	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>	—	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>
BUSINESS PHONE NUMBER		BUSINESS FAX NUMBER		

Section 5C. PREFERRED MAILING ADDRESS

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future registration documents will be mailed. The address that will appear on your registration will be your business address.

☐ HOME ☐ BUSINESS

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Section 6A. PROFESSIONAL SCHOOLS ATTENDED

List all colleges and universities attended prior to and including professional schools. List in reverse chronological order, beginning with the most recent at the top.

School Name, City, State, Country	Number of Hours Completed	Date of Graduation	Type of Degree/Certificate

Section 6B. POSTGRADUATE EXPERIENCE

List all experience since graduation from college, university or professional school, in reverse chronological order, beginning with the most recent. For "Type of Position," use the letter from the key below.

Organization/Institution	Location	Start Date	End Date	Type of Position (Use Key Below)*	Full Time	Part Time

*** TYPE OF POSITION KEY**

- A. Employment
- B. Private Practice
- C. Clinical Rotations
- D. Instructor
- E. Other (specify on separate sheet of paper)

Section 6C. PROFESSIONAL REGISTRATION IN OTHER STATES/JURISDICTIONS

List all states and jurisdictions in which you have ever held a similar professional registration. You must request and provide verification of registration for all of these registrations, past and/or present.

Jurisdiction	Date Registration Was First Obtained	Registration Number

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SECTION 7. QUESTIONS – Applicants MUST answer all of the following questions.

Please answer all of the following questions by placing an "X" in the appropriate boxes. If you answer "Yes" to questions B through J below, you must provide full information and complete details on a separate sheet of paper, including copies of relevant court documents, and attach to this application.

**HPLA
ONLY**

Clean Hands Before Receiving a Registration or Permit Act of 1996 Certification Form Requirement.

Please read the information below carefully before responding to this yes or no question, as **any false information provided requires that the Department of Health proceed immediately to revoke your Registration or Permit** for which you are now applying, and fine you one thousand dollars (\$1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR APPLICATION BE DENIED.

As of this date, do you owe more than one hundred dollars (\$100.00) to the District of Columbia Government as a result of any of the following:

Yes No
☐ ☐

- A. 1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);
2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
4. Past due taxes;
5. Past due District of Columbia Water and Sewer Authority service fees; or
6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)?

The information presented above is in compliance with the requirement to submit with your application for registration or permit under the *Clean Hands Before Receiving a Registration or Permit Act of 1996*, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).

Y N
☐ ☐

- B. Have you ever been convicted or arrested for a crime or misdemeanor (other than minor traffic violations) not previously reported to the Board?

YES NO
☐ ☐

☐

- C. Are you now or have you ever been registered or licensed in DC or any other state/jurisdiction? (If "Yes," be sure to complete section 6C of this form.)

YES NO
☐ ☐

☐

- D. Have you ever been party to a malpractice action or had a malpractice action brought against you?

YES NO
☐ ☐

☐

- E. Have you ever voluntarily surrendered a registration or license after formal charges have been filed against you or while under investigation?

YES NO
☐ ☐

☐

- F. Have you ever been terminated from or resigned from a clinical or professional training program?

YES NO
☐ ☐

☐

- G. Do you have a physical or medical condition that currently impairs your ability to practice your profession?

YES NO
☐ ☐

☐

- H. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?

YES NO
☐ ☐

☐

- I. (1) Have you withdrawn an application (in D.C. or any other state/jurisdiction) to practice your profession? (2) Has any authority or peer review board taken adverse action against your registration, license or privileges? (3) Are you currently under investigation or were you investigated by any authority or peer review board for any violation of state, federal, or local law? (4) Has any authority or peer review board informed you of any pending charges(s) or investigation not previously reported to this Board?

YES NO
☐ ☐

☐

- J. Have you ever been terminated or asked to resign from employment since obtaining your (professional) registration or license?

YES NO
☐ ☐

☐

SECTION 8. REGISTRANT AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

**HPLA
ONLY**

REGISTRANT SIGNATURE

NAME (Please Print)

DATE

☐

To report waste, fraud, or abuse by any DC Government office or official, call the DC Inspector General at 1-800-521-1639.